Medicare Bulletin

Jurisdiction 15

KENTUCKY & OHIO PART B

Reaching Out to the Medicare Community

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Medicare Bulletin

Jurisdiction 15

KENTUCKY & OHIO

Administration

Checking Beneficiary Eligibility and Claim Status 3

Use myCGS to Submit Your Responses to Medical Review (MR) Additional Documentation Requests (ADRs)! 6

Letter From The Home Health Contractor Medical Directors (CMDs) 9

Coding

Billing Update for Zoledronic Acid – J3489 3

Mohs Micrographic Surgery: Claim Submission Reminders 5

Not Otherwise Classified (NOC) Drugs: Clarification on Required Information 6

MM9167 Revised: Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/ Biological Code Changes - July 2015 Update 7

SE1315 Rescinded: Pulmonary Procedures and Evaluation & Management (E/M) Services 13

Enrollment & Credentialing

SE1425 Revised: Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers 17

Fee Schedules & Reimbursement

MM9248: October 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files 12

ICD-10

SE1408 Revised: Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD -10) – A Re-Issue of MM 7492 13

Laboratory & Pathology

MoPath: GeneSight® Assay for Refractory Depression Claims Submission Reminders (Part B) 6

Preventive Services

MM9200: Screening for Hepatitis C Virus (HCV) in Adults – Implementation of Additional Common Working File (CWF) and Shared System Maintainer (SSMs) Edits 10

NEWS FLASH

News Flash Items 19

Medicare Learning Network®

Official Information Health Care Professionals Can Trust

http://go.cms.gov/MLNGenInfo

Articles contained in this edition are current as of July 28, 2015.

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Medicare Learning Network®: A Valuable Educational Resource!

The Medicare Learning Network® (MLN), offered by the Centers for Medicare & Medicaid Services (CMS), includes a variety of educational resources for health care providers. Access Web-based training courses, national provider conference calls, materials from past conference calls, MLN articles, and much more. To stay informed about all of the CMS MLN products, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf and subscribe to the CMS electronic mailing lists. Learn more about what the CMS MLN offers at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the CMS website.

Kentucky & Ohio

Billing Update for Zoledronic Acid – J3489

CGS has been made aware of a potential program vulnerability based on the coding and billing of zoledronic acid. Prior to 2014, coding was in place for zoledronic acid marketed under the brand names Zometa® (J3487) and Reclast® (J3488). Effective in 2014, the HCPCS code J3489 was developed and is now used to reflect both drugs which have different dosages and administration frequency, beginning with service date **September 1, 2015**.

When administering Reclast® CGS will require the KX modifier to be appended to the claim submissions.

Kentucky & Ohio

Checking Beneficiary Eligibility and Claim Status

CGS has seen an increase in calls to the Provider Contact Center from providers asking for Medicare beneficiary eligibility information and wanting to check the status of submitted claims. According to the Centers for Medicare & Medicaid Services (CMS) **providers are required to use the Interactive Voice Response (IVR) system for claim status and eligibility information**. Refer to the CMS Medicare Contractor Beneficiary and Provider Communications Manual, (Pub. 100-09), Chapter 6, section 50.1 (http://www.cms.gov/manuals/downloads/com109c06.pdf), which states:

> Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning.

Available Self-Service Tools

CGS offers the IVR for providers to check Medicare beneficiary eligibility and claim status. In addition, the CGS Web portal, myCGS, is available. Both tools allow providers access to this information 24 hours a day, seven days a week; however, information that can only be obtained by accessing other systems may not be available 24/7.

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RETURN TO TABLE OF CONTENTS

Interactive Voice Response (IVR) - 1.866.290.4036

- "CGS Jurisdiction 15 Part B Interactive Voice Response (IVR) User Guide" http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
- Obtain the following information via the CGS IVR:
  - Patient eligibility;
  - Claim status and deductible;
  - Redetermination status;
  - Checks issued; and
  - General information.
- To access information via the IVR, you must provide the following information:
  - National Provider Identifier
  - Provider Transaction Access Number (PTAN)
  - Provider Tax Identification Number (TIN) (last 5 digits)

myCGS

- Your Electronic Gateway to Self-Service: myCGS — The Jurisdiction 15 Web Portal http://www.cgsmedicare.com/partb/myCGS/index.html
- The following information is available through myCGS:
  - Patient eligibility;
  - Claim status;
  - View and print Remittance Advices (RAs);
  - Payment information (payment floor) and recently issued check data;
  - Immediate Offset (eOffset);
  - Submit Part B claims;
  - Submit Part B Reopenings;
  - Submit Redetermination requests, and check the status of submitted requests; and
  - Submit medical review additional development requests (ADRs) documentation.

Please remind your billing staff to use these resources before contacting a CGS Customer Service Representative (CSR) for beneficiary eligibility and/or claim status information.

Kentucky & Ohio

Mohs Micrographic Surgery: Claim Submission Reminders

Our Part B Medical Review department has noticed an increase in the number of claims submitted for Mohs Micrographic Surgery (MMS) with CPT code 17311 - 17315 (performed on the trunk or extremities) that do not include documentation, as noted in the "General Information" section of the Mohs Micrographic Surgery Local Coverage Determination (LCD) L31877) http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=31877&ContrId=228&ver=25&ContrVer=2&CntrctrSelected=228*2&Cntrctr=228&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&DocType=All&DocStatus=Active&s=22&bc=AggAAAIAAAAAAA%3d%3d&).

To ensure your claims are processed in the most efficient manner, please keep in mind documentation identifying **one or more of the qualifying terms** listed under "Indications

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RETURN TO TABLE OF CONTENTS

and Limitations of Coverage" must be included. This information may be submitted either in the documentation field of your electronic claim, as an attachment to a myCGS eClaim (http://www.cgsmedicare.com/partb/pubs/news/2015/0415/cope29055.html), using the PWK segment (http://www.cgsmedicare.com/partb/pubs/news/2013/0213/cope21311.html) process, or in Item 19 of your CMS-1500 claim form.

Including this documentation upon initial submission will help avoid delays in processing, as additional documentation request (ADR) letters will be sent if this information is not received.

Kentucky & Ohio

MoPath: GeneSight®Assay for Refractory Depression Claims Submission Reminders (Part B)

The Medical Review department has noticed an increase in claim submissions for GeneSight® with referrals from specialties other than licensed psychiatrists. As indicated in LCD L35437 MoPath: GeneSight® Assay for Refractory Depression (and its ICD-10 equivalent, L35443), this test should only be ordered/referred by a licensed psychiatrist. If any other specialty orders/refers this test, it will be considered not medically necessary.

To ensure your claims are processed in the most efficient manner, please enter the name of the test (GeneSight) in the narrative/comment section on electronic claims in loop 2400 NTE02 for Part B. For paper claims, submit the test name in Item 19 for Part B. A payable ICD-9 code, if appropriate, is needed for payment consideration.

- https://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=~/overview-and-quick-search.aspx&npage=/medicare-coverage-database/details/lcd-details.aspx&LCDId=35437&ContrId=228&ver=3&ContrVer=2&CntrctrSelected=228*2&Cntrctr=228&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&DocType=Active&DocStatus=Active&s=22&bc=AggAAAIAAAAAAA%3d%3d&
- https://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=~/overview-and-quick-search.aspx&npage=/medicare-coverage-database/details/lcd-details.aspx&LCDId=35443&ContrId=228&ver=2&ContrVer=2&CntrctrSelected=228*2&Cntrctr=228&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&LCntrctr=228*2&DocType=Future&bc=AgACAAIAAAAAAA%3d%3d&

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Not Otherwise Classified (NOC) Drugs: Clarification on Required Information

Claims for HCPCS codes J9999 (not otherwise classified anti-neoplastic drugs), J3490 (unclassified drugs) and/or J3590 (unclassified biological drugs) must be submitted with additional qualifying information. These claims must include:

- The name of the drug
- The National Drug Code (NDC) number
- The exact dosage given

Claim Submission:

- For electronic claims, Loop/Element 2400 SV101-7 must be completed for Not Otherwise Classified (NOC) codes. The required documentation (name, NDC and dosage) may be submitted in Loop/Element 2400 SV101-7. If additional space is needed, Loop 2400 NTE 02 may be utilized in addition to SV101-7.

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RETURN TO TABLE OF CONTENTS

- For paper claims, the documentation must be in Item 19.

New NOC Code for Compounded Drugs

As a result of Change Request (CR) 9167 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3254CP.pdf), effective for claims with dates of service on and after July 1, 2015, claims for compounded drugs must be submitted using the new compounded drug not otherwise classified (NOC) HCPCS code Q9977.

Using HCPCS code Q9977 is intended to distinguish compounded drugs (which may include biologicals) from the other drug NOC codes listed above.

The same claim submission instructions noted above apply to HCPCS code Q9977.

Kentucky & Ohio

Use myCGS to Submit Your Responses to Medical Review (MR) Additional Documentation Requests (ADRs)!

myCGS is our free secure online Web portal where providers can now respond to medical review (MR) additional documentation requests (ADRs). When medical records are requested to correctly adjudicate a claim, myCGS is a convenient way to ensure an accurate and timely response. Documentation in response to an MR ADR must be received by CGS on/before 45 calendar days of the request.

Why myCGS?

- myCGS allows you to submit attachments as PDF (Portable Document Format) documents. Save documents in a PDF format by using a scanner or various versions of commercially-available software.
  - Attach up to 5 PDF documents (up to 5MB each)
  - Save PDF documents in a folder on your system to allow easy access
  - Saved PDF documents help to identify what medical records were submitted to CGS
- myCGS validates the patient and claim information you enter, ensuring the documentation is matched correctly to the claim being reviewed.
- myCGS provides a "Secure Form Received" message confirming CGS has received the MR ADR documentation you submitted.
  - myCGS provides a second message, "Secure Form Confirmation" which assigns a Submission ID to your MR ADR submission that can be used to track the status of your response.
- myCGS eliminates doubts that all the documentation you faxed was received and matched with the appropriate claim.
- myCGS eliminates personnel from mishandling the medical record documentation.
- myCGS eliminates postage expense.

For detailed instructions about submitting your documentation in response to an MR ADR, refer to "Chapter 7: Forms Tab" at http://www.cgsmedicare.com/pdf/mycgs/chapter7_partb.pdf of the *myCGS User Manual* or the "myCGS MR ADR Job Aid" at http://cgsmedicare.com/partb/pubs/news/2015/0415/cope28413.html

If you do not have access to myCGS, refer to the "Your Electronic Gateway to Self-Service: myCGS – The Jurisdiction 15 Web Portal" Web page at http://www.cgsmedicare.com/partb/myCGS/index.html for additional information.

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RETURN TO TABLE OF CONTENTS

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A/B MAC JURISDICTION 15
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We IMPACT lives.

Dear Colleague:

Medicare has changed the physician documentation requirements for certification of home health care for dates of service effective January 1, 2015. While clinicians still need to certify benefit eligibility and a face to face encounter is still required, the need for extra documentation (e.g., the "narrative") has been scaled back or eliminated. These remaining requirements may be billed in the following manner: a face-to-face encounter with a physician or allowed non-physician practitioner is billed with an evaluation and management (E&M) code and the certification is billed with G0180 (G0179 for recertification). The home health agency will provide medical records from the office or hospital setting describing the patient's condition and supporting his/her eligibility for home care prior to your completion of the certification document. The agency may need progress notes from you or hospital records of the face-to-face visit if it was done in the hospital setting in order to substantiate the reason home health care is needed.

In review, to qualify for the Medicare Home Health Benefit beneficiaries must have Medicare Part A and/or Part B and meet all of the following requirements:

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and periodically reviewed by a physician; and
- Have a face-to-face encounter with a physician or allowed non-physician practitioner (NPP) (reviewed and counter-signed by the physician).

Your Home Health/Hospice Medicare contractor's website may be accessed to obtain information regarding eligibility and documentation requirements. Additional references are as follows:

- CMS MLN Article (MM9119 Revised) Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services
- Certifying Patients for the Medicare Home Health Benefit
- Medicare Home Health Agency (HHA) Center

Sincerely,

Contractor Medical Directors
Home Health/Hospice Medicare Contractors

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CGS Administrators, LLC is a Medicare Part A, B, Home Health and Hospice, and DME Medicare Administrative Contractor for the Centers for Medicare & Medicaid Services.

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MM9167 Revised: Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/ Biological Code Changes - July 2015 Update

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9167 *Revised*
Related CR Release Date: July 10, 2015
Related CR Transmittal #: R3292CP
Related Change Request (CR) #: CR 9167
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Note: This article was revised on July 20, to reflect the revised CR9167 issued on July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR9167 are revised. On July 22, 2015, the article was revised further to include additional language from the revised CR9167. This additional language is in the note box on page 3 of this article. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes.

CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the "Claims Processing Manual" to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167

CR9167 adds the following HCPCS codes with the effective dates noted.

Table 1 - New HCPCS Codes in CR9167

Effective for Claims with Dates of Service on or after:	HCPCS Code	Long Description	Short Description	Type of Service (TOS)
March 6, 2015	Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
July 1, 2015	Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron	Inj Ferric Pyrophosphate Cit	1, L
July 1, 2015	Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	Netupitant Palonosetron oral	1
July 1, 2015	Q9977	Compounded Drug, Not Otherwise Classified	Compounded Drug NOC	1, P

Note: The Medicare Physician Fee Schedule Status Indicator for all four codes above is E.

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the "Medicare Claims Processing Manual" to address the use of a compounded drug NOC code on claims for compounded drugs.

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RETURN TO TABLE OF CONTENTS

Please note: The new compounded drug code, Q9977 - Compounded Drug, Not Otherwise Classified, is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other "not otherwise classified" codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the "Medicare Claims Processing Manual," Chapter 17, Section 20.1.2..

Additional Information

The official instruction, CR 9167 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3292CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

MM9200: Screening for Hepatitis C Virus (HCV) in Adults – Implementation of Additional Common Working File (CWF) and Shared System Maintainer (SSMs) Edits

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9200
Related CR Release Date: June 19, 2015
Related CR Transmittal #: R3285CP
Related Change Request (CR) #: CR9200
Effective Date: June 2, 2014
Implementation Date: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems edits.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Hepatitis C Virus (HCV) screening services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9200 informs providers that beneficiaries born prior to 1945 or after 1965 with no risk factors for HCV are not eligible for HCV screening benefits as described in CR8871, Transmittal 3215, dated March 11, 2015. CR9200 also removes Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and Method II Critical Access Hospitals (CAHs) as valid facilities for these HCV screening services. Make sure that your billing staffs are aware of these changes.

Background

Effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) covers screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force for the prevention or early detection of an illness or disability, and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. This policy was implemented in CR8871. You may want to review the related MLN Matters® article

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RETURN TO TABLE OF CONTENTS

MM8871 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8871.pdf) for additional claims processing instructions.

As indicated in CR8871, and replicated in CR9200 for ease of reference only, CMS covers screening for HCV with the appropriate U.S. Food and Drug Administration (FDA)- approved/cleared laboratory tests, and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices), used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. A screening test is covered for adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. A single screening test is covered for adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

Key Points

- For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk as defined in the policy, HCV screening is limited to once per lifetime. New HCPCS code G0472 (short descriptor - Hep C screen high risk/other, and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s)) will be used.
- Beneficiaries born prior to 1945 or after 1965 with no risk factors are not eligible for this benefit.
- For those beneficiaries determined to be high-risk initially as defined in the policy, regardless of birth year, ICD-9 diagnosis code V69.8, "other problems related to life style" (when ICD-10 is implemented ICD-10 diagnosis code Z72.89, "other problems related to lifestyle") is required in addition to HCPCS G0472.
- Coverage of a sub-set of the above high risk beneficiaries may occur on an annual basis if appropriate as defined in the policy, regardless of birth year, denoted by the presence of HCPCS G0472, ICD diagnosis code V69.8/Z72.89, and ICD diagnosis code 304.91, "unspecified drug dependence continuous"/F19.20, "other psychoactive substance abuse, uncomplicated" (once ICD-10 is implemented). Annual is defined as 11 full months must pass following the month of the last negative HCV screening.
- HCV screening, HCPCS code G0472, is a technical service only and there is no professional fee.
- CR9200 also removes the following facilities as valid for HCV screening services:
  - RHC, TOB 71X;
  - FQHC, TOB 77X; and
  - CAH Method II, professional services, TOB 85X with revenue code 096X, 097X, or 098X.
- MACs will line-item deny claims for HCV screening, HCPCS G0472, for beneficiaries born prior to 1945 and after 1965 who are not high risk with the following messages:

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RETURN TO TABLE OF CONTENTS

- CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.; and
- Group Code CO – assigning financial liability to the provider.

Note: Only HCPCS G0472 as noted above should be reported for this new HCV screening benefit. CPT code 86803, HCV rapid antibody test, is not appropriate for reporting screening under this policy.

Additional Information

The official instruction, CR9200 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3285CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

MM9248: October 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9248
Related CR Release Date: July 10, 2015
Related CR Transmittal #: R3290CP
Related Change Request (CR) #: CR 9248
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9248 which instructs MACs to download and implement the October 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2015, April 2015, January 2015, and October 2014, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2015, with dates of service October 1, 2015, through December 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

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RETURN TO TABLE OF CONTENTS

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf).

The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional Information

The official instruction, CR9248 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3290CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

SE1315 Rescinded: Pulmonary Procedures and Evaluation & Management (E/M) Services

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1315 *Rescinded*
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Related Change Request (CR) #: Not Applicable
Effective Date: N/A
Implementation Date: N/A

Note: This article was rescinded on July 27, 2015.

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RETURN TO TABLE OF CONTENTS

SE1408 Revised: Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1408 *Revised*
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Related Change Request (CR) #: 7492
Effective Date: October 1, 2014
Implementation Date: N/A

Note: This article was revised on June 27, 2015, to clarify language under "Claims that Span the ICD-10 Implementation Date". All other information remains the same.

Provider Types Affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date.** Make sure your billing and coding staffs are aware of these changes.

Key Points of SE1408

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to http://www.cms.gov/Medicare/Coding/ICD10/index.html for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes

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RETURN TO TABLE OF CONTENTS

and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that Span the ICD-10 Implementation Date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	**THROUGH**
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	**THROUGH**

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RETURN TO TABLE OF CONTENTS

Table A – Institutional Providers			
Bill Type(s)	**Facility Type/Services**	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	**THROUGH**
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	**THROUGH**
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	***See Note**
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	**N/A**
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
83X	Hospice – Hospital Based	N/A	**N/A**
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**

Table B - Special Outpatient Claims Processing Circumstances		
Scenario	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
3-day/1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	**THROUGH**

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RETURN TO TABLE OF CONTENTS

Table C – Professional Claims		
Type of Claim	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.	**FROM**

Table D –Supplier Claims		
Type of Claim	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).	**FROM**

Additional Information

You may also want to review SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

SE1425 Revised: Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1425 *Revised*
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on July 27, 2015, to reflect an extension of the temporary moratoria for an additional 6 months, as noted in the article.

Provider Types Affected

This MLN Matters® Article is intended for home health agencies, home health agency sub-units, and part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective July 29, 2015, the temporary moratoria on new home health agencies, home health agency sub-units, and part B ground ambulance suppliers are being extended for an additional 6 months in certain geographic locations.

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RETURN TO TABLE OF CONTENTS

CAUTION – What You Need to Know

During the 6-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

GO – What You Need to Do

Effective July 29, 2015, home health agencies, home health agency sub-units, and part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the 6-month moratoria has expired. CMS will announce in the Federal Register when the moratorium has been lifted, extended, or changed.

Background

In accordance with 42 CFR §424.570(c) (http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec424-570.pdf), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On July 28, 2015, CMS announced, in a Federal Register notice (http://federalregister.gov/a/2015-18327), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and the implementation was announced in the Federal Register which may be accessed on the internet at: https://federalregister.gov/a/2013-18394. The moratoria were expanded on January 30, 2014, and the expansion was announced in the Federal Register which may be accessed at: https://federalregister.gov/a/2014-02166.

Moratoria Extension

Effective July 29, 2015, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional 6 months in the areas stated in Table 1, below.

Table 1: Home Health Agencies and Home Health Agency Sub-units under Temporary Moratorium

City and State	Counties	City and State	Counties
Fort Lauderdale, FL	Broward	Dallas, TX	Collin, Dallas, Denton, Ellis, Kaufman, Rockwall, Tarrant
Miami, FL	Miami-Dade, Monroe	Houston, TX	Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, Waller
Detroit, MI	Macomb, Monroe, Oakland, Washtenaw, Wayne	Chicago, IL	Cook, DuPage, Kane, Lake, McHenry, Will

In addition, the temporary moratorium on new part B ground ambulance suppliers is being extended for an additional 6 months in the areas stated in Table 2, below.

Table 2: Part B Ambulance Suppliers Under 6-month Temporary Moratorium

City and State	Counties			
Houston, TX	Harris Brazoria	Chambers Fort Bend	Galveston Liberty	Montgomery Waller
Philadelphia, PA	Bucks (PA) Delaware (PA)	Montgomery (PA) Philadelphia (PA)	Burlington (NJ) Camden (NJ)	Gloucester (NJ)

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RETURN TO TABLE OF CONTENTS

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Note: Home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional Information

For more information regarding CMS' use of temporary moratoria, please review MLN Matters® article MM7350 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Kentucky & Ohio

News Flash Items

- **June is Men's Health Month** - Medicare provides coverage of a wide range of preventive services, subject to certain eligibility and coverage requirements that are especially meaningful to men in helping to prevent and detect disease. You can help your patients make the most of their benefits by talking with them about their risk factors for disease and encouraging them to take advantage of the preventive services covered by Medicare that are most appropriate for them. Continue reading (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2015-06-11-Mens-Health.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending) to learn more about Medicare-covered preventive service.
- **NEW products from the Medicare Learning Network®**
  - "The DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet," Fact Sheet, ICN 905283, downloadable https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Repair_Replacement_Factsheet_ICN905283.pdf
- **Revised product from the Medicare Learning Network® (MLN)**
  - ICD-10-CM/PCS Billing and Payment Frequently Asked Questions, Fact Sheet (ICN 908974) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10BillingandPaymentFAQs.pdf
  - "Internet-based PECOS Contact Information" Fact Sheet, ICN 903766, downloadable http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf
  - "ICD-10-CM Classification Enhancements," (http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10QuickRefer.pdf) Fact Sheet, ICN 903187, Downloadable only.

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RETURN TO TABLE OF CONTENTS